

LICENSEE EVENT REPORT

CONTROL BLOCK: _____ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 MIDCC 2 2 00-000000-00 3 41111 4 5
7 8 9 14 15 25 26 30 37 38

01 REPORT SOURCE L 6 05000316 7 032582 8 042382 9
7 8 9 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10
02 DURING A PREVENTIVE MAINTENANCE INSPECTION, ROLL-UP FIRE DOOR #344 WOULD NOT
03 CLOSE UPON AUTOMATIC CLOSURE ACTIVATION. THIS CONSTITUTED AN INOPERABLE
04 PENETRATION FIRE BARRIER, CONTRARY TO T.S. 3.7.10. PUBLIC HEALTH AND SAFETY
05 WERE NOT AFFECTED. THIS IS A FIRST OCCURRENCE. (SEE ATTACHMENT)
06
07
08

09 SYSTEM CODE AB 11 CAUSE CODE B 12 CAUSE SUBCODE C 13 COMPONENT CODE XXXXX 14 COMP SUBCODE Z 15 VALVE SUBCODE Z 16
7 8 9 10 11 12 13 18 19 20
17 LER NO REPORT NUMBER 82 21 SHUTDOWN METHOD Z 21 HOURS 0000 22 ATTACHMENT SUBMITTED Y 23 NPRO-4 FORM SUB. N 24 PRIME COMP. SUPPLIER A 25 COMPONENT MANUFACTURER K146 26
23 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27
10 THE DISCHARGE SPRING TORQUING MECHANISM APPEARED TO HAVE BEEN ASSEMBLED DURING
11 MANUFACTURE WITH AN IMPROPERLY SIZED TRAVELING LINK. THE BROKEN SPIRAL AND
12 TRAVELING LINK WERE REPLACED AND SIMILAR DOORS ARE BEING INSPECTED.
13 (SEE ATTACHMENT).
14

15 FACILITY STATUS G 28 % POWER 000 29 OTHER STATUS NA 30 METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION PREVENTIVE MAINTENANCE INSPECTION 32
7 8 9 10 12 13 44 45 46 80
16 ACTIVITY CONTENT Z 32 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE NA 36
7 8 9 10 11 44 45 80
17 PERSONNEL EXPOSURES NUMBER 000 37 TYPE Z 38 DESCRIPTION NA 39
7 8 9 10 11 12 13 80
18 PERSONNEL INJURIES NUMBER 000 40 DESCRIPTION NA 41
7 8 9 10 11 12 80

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION NA 43
7 8 9 10 80
20 PUBLICITY ISSUED N 44 DESCRIPTION NA 45
7 8 9 10 80

8204300262

SUPPLEMENT TO LER # 82-024/03L-0

SUPPLEMENT TO EVENT DESCRIPTION:

FIRE DOORS BECAME T.S. RELATED ON APRIL 1, 1982. DURING A PRELIMINARY PREVENTIVE MAINTENANCE INSPECTION, DOOR #344 WAS FOUND INOPERABLE ON MARCH 25, 1982. DUE TO AN OVERSIGHT, A SHIFT SUPERVISOR CLEARANCE TO MAINTAIN THE DOOR IN A CLOSED POSITION WAS NOT REQUESTED UNTIL APRIL 1, MAKING THE EVENT REPORTABLE PER T.S. 3.7.10. PUBLIC HEALTH AND SAFETY WERE NOT AFFECTED. THIS IS A FIRST OCCURRENCE.

SUPPLEMENT TO CAUSE DESCRIPTION:

UPON DISASSEMBLY OF THE DISCHARGE SPRING TORQUING MECHANISM, IT WAS DETERMINED THAT AN OVERSIZED TRAVELING LINK HAD BEEN INSTALLED, APPARENTLY DURING MANUFACTURE. THE OVERSIZED TRAVELING LINK, #013-0003, BROKE OUT SECTIONS OF THE CHANNEL WALLS OF THE SPIRAL, #013-0091. THE BREAKAGE PREVENTED THE DISCHARGE SPRING FROM TORQUING. WITHOUT TENSION ON THE DISCHARGE SPRING, THE DOOR WOULD NOT CLOSE UPON AUTOMATIC CLOSURE ACTIVATION. THE SPIRAL AND TRAVELING LINK WERE REPLACED. THE DOOR TESTED SATISFACTORILY.

ALL SIMILAR DOORS ARE BEING DISASSEMBLED AND INSPECTED FOR PROPER SIZE OF THE TRAVELING LINK AND DAMAGE TO THE SPIRAL.